An Analysis of Idaho's Juvenile Justice Substance Use Disorder Services Delivery System Among Juveniles Discharged from Services in Fiscal Year 2012

A Working Paper of Analyses and Results

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Executive Summary

During the past several years, the state of Idaho invested major efforts into restructuring the delivery of mental health and substance abuse services. As a result of these efforts, effective July 1, 2011, the state funds appropriated to support provision of substance use disorder (SUD) services in Idaho were divided among four state entities: the Idaho Department of Health and Welfare (IDHW), the Idaho Department of Correction (IDOC), the Idaho Department of Juvenile Corrections (IDJC), and the Judiciary. IDJC was assigned the administration of the funds appropriated to serve justice-involved juveniles and established the JJ SUD services delivery system.

In an effort to develop a more standardized SUD services delivery system, IDJC contracted with researchers from the Center for Health Policy (CHP) at Boise State University (BSU) to conduct an evaluation of the JJ SUD services delivery system. The evaluation consisted of data collected in two waves. The first wave involved the analysis of claims data; this information included county of supervision, length of stay, cost and level of treatment, treatment frequency, and discharge reason for juveniles who received services in Fiscal Year (FY) 2012. The second wave of data collection involved information gleaned through surveys of various stakeholders, including judges, court administrators, county juvenile justice staff, chief probation officers and directors, private providers, and others who work with justice-involved juveniles; these surveys asked questions about the stakeholders' perceptions regarding the effectiveness of the current JJ SUD services delivery system.

Key findings from each of the two waves of data collection are presented below.

<u>Wave One: IDJC Data:</u>

- **Characteristics of the 321 juveniles who were served in the JJ SUDS system and discharged were analyzed**
  - **Close to 76% of the juveniles in the final data set were male, and just over 24% were female**
  - **The largest percentages of juveniles received SUD services in District 3 and District 4 (over 21% each)**

- **Nearly 88% of the juveniles received both an assessment and treatment services. Nearly 13% received an assessment only (followed by no treatment)**

- **Nearly 60% of the juveniles who were included in this study were assessed and began the treatment episode in FY 2011 and were transferred into the new JJ SUDS system on July 1, 2011. The remaining 40% were assessed and began their treatment episode in FY 2012**

- **Nearly 86% received only outpatient care, whereas nearly 14% received some residential care (either alone or in combination with outpatient care)**

- **The two most common providers of outpatient treatment were D7 Treatment Program and Family Services Center (accounting for 12% and 11% of juveniles**

treated in outpatient care, respectively). The two most common providers of residential services were Bannock Youth Foundation and Bell Chemical Dependency (36% and 29% of juveniles treated in residential care, respectively)

- **The most commonly documented reasons for patient discharge were "Completed Treatment Successfully" and "Client Moved, Unknown" (each of which was reported for nearly 40% of the juveniles)**

- **The average length of stay in terms of receiving SUD treatment services was 169 days, or approximately five and a half months, with a range from 14 days to 533 days (nearly 18 months)**
    - **Nearly 81% of juveniles in outpatient care engaged in treatment over 90 days, with 33% engaging in treatment for more than 180 days**
    - **Nearly 79% of juveniles in residential care at some point in their treatment episode were engaged in treatment over 90 days, with nearly 53% engaging in treatment for more than 180 days**
    - **Juveniles receiving residential care at some point in their treatment episode (213 days) had a longer average length of stay than juveniles receiving only outpatient care (162 days)**

- **The average treatment frequency for juveniles receiving SUD services was 35 sessions, with a range from one session to 183 sessions**
    - **Over 67% of juveniles in outpatient care attended 13 sessions or more; 27% attended 73 sessions or more**
    - **Slightly over 92% of juveniles in residential care attended 37 sessions or more, with over 63% attending 73 sessions or more**
    - **Juveniles receiving residential care at some point in their treatment episode (86 sessions) had a greater average treatment frequency than juveniles receiving only outpatient care (27 sessions)**

- **The average length of time between assessment and first treatment service was 20 days, with a range from the same day to 90 days (or three months)**
    - **Of the 177 cases in which data were available, the 89 juveniles assessed in FY 2012 (23 days) had a longer average length of time between assessment and first treatment service than the 88 juveniles assessed in FY 2011 (17 days)**

- **The average client cost for all juveniles was $2,438, with a range between $11 and $20,423**
    - **Juveniles receiving residential care at some point in their treatment episode had an average cost of $12,860; nearly 74% of juveniles in residential care at some point in their treatment episode were served at a cost over $10,000, and nearly 45% were served at a cost over $15,000**
    - **Juveniles receiving only outpatient care had an average cost of $1,191; nearly 91% of juveniles in outpatient services were served at a cost of under $3,001 for their treatment, and nearly 56% were served at a cost of under $1,001**

- **For the 112 juveniles who discharged in the first quarter of the year, a one-year review of court filings revealed that 40% of those juveniles that received treatment were reported to have recidivated (or had been adjudicated of a new crime) within one year from the termination of treatment**
    - **Recidivism rates for this first year of data did not significantly differ as a function of level of care, type of service, average length of stay, average cost per client, discharge reason, or YLS/CMI risk factor scores**
    - **Juveniles who received their first treatment service 11 days or longer after assessment (43%) had a higher average recidivism rate than juveniles receiving a first treatment within 10 day of assessment (14%)**

<u>Wave Two: Stakeholder Survey Data:</u>

- **The majority of respondents completing a survey reported themselves to be county juvenile justice staff (34%), county probation officers/directors (25%), or treatment providers (19%)**

- **Nearly 80% of the respondents reported working with juveniles for more than six years, and 55% reported working with juveniles for 11 or more years**

- **Nearly 92% of the respondents agreed that juveniles on probation in need of SUD treatment are able to receive it in the new JJ SUD services delivery system**
    - **The longer respondents reported working with juveniles, the less likely they were to agree that juveniles on probation in need of SUD treatment were able to receive it in the new JJ SUD services delivery system**

- **Eighty-five percent of the respondents agreed that juveniles on probation in need of SUD treatment were able to access the appropriate level of care to meet their individual needs in the new JJ SUD services delivery system**
    - **The longer respondents reported working with juveniles, the less likely they were to agree that juveniles on probation in need of SUD treatment were able to access the appropriate level of care to meet their individual needs in the new JJ SUD services delivery system**

- **Nearly 83% of the respondents agreed that coordination of treatment with the judge's order and probation terms results in more likelihood of success for the juveniles**

- **Over 78% of the respondents agreed that the time from referral to assessment has decreased with the local authorization process**
    - **Chief probation officers and directors agreed more strongly that the time from referral to assessment has decreased with the local authorization process than providers**

- **Nearly 94% of the respondents agreed that communication between the providers and probation is critical to the success of the client**
    - **The longer respondents reported working with juveniles, the less likely they were to agree that communication between the providers and probation is critical to the success of the client**

- **Over 77% of the respondents agreed that communication between the providers and probation has been enhanced with local management of treatment services**

- **Seventy-four percent of the respondents agreed that there is adequate information regarding the clients currently in treatment to allow oversight and local management**
    - **Chief probation officers and directors agreed more strongly that there is adequate information regarding the clients currently in treatment to allow oversight and local management than providers**

- **Sixty-seven percent of the respondents agreed that there was adequate information regarding treatment expenditures to allow management and accountability of the system**
    - **Chief probation officers and directors agreed more strongly that there is adequate information regarding treatment expenditures to allow management and accountability of the system than providers**

- **In response to an open-ended item asking the respondents what additional information would be helpful to their teams in managing the system, the most common response theme was that communication between different parts of the system (particularly providers and probation) should be encouraged; the second-most common theme was that no additional information was needed and that the system in place was working well**

- **Twenty-eight percent of the respondents reported perceiving that there were barriers or challenges in the system that prevented access to services for juveniles in their area. Nearly 49% reported perceiving that no such barriers or challenges exist, while over 23% were not sure/did not know**
    - **Among the respondents who reported perceiving that there were barriers or challenges in the system that prevented access to services for juveniles in their area, nearly 43% reported these barriers to be related to the lack of providers in their area or transportation problems. The second-most common response theme was that treatment was not available to non-adjudicated juveniles**

- **On a profession-specific item targeted to chief probation officers and directors, 45% of the respondents in this group reported that county-funded programs for SUD treatment were available in their county, whereas 55% reported they were not**
- **On a profession-specific item targeted to chief probation officers and directors, the respondents estimated that an average of three hours of administrative time was used each week for SUD services**
- **On a profession-specific item targeted to providers, nearly 71% of the respondents in this group reported there has been good support to the provider network in the transition process to a locally managed system for juvenile justice clients**
- **In a response to a final item asking all respondents for any feedback that could be helpful to IDJC in either supporting district teams or working with stakeholders as the system developed, the most common theme that emerged (in the responses of over 32% who completed this item) was that the current system is working well; the second most common theme was that there were perceivable improvements with the JJ SUD services delivery system**

Introduction

Several major changes in the substance abuse disorder (SUD) services delivery system in Idaho have resulted from the ongoing efforts of the state of Idaho to restructure the system of delivery of mental health and substance abuse services. One such change is redistribution of state funds appropriated to support provision of SUD services in Idaho. Effective July 1, 2011, the state funds were divided among four state entities: the Idaho Department of Juvenile Corrections (IDJC), the Idaho Department of Correction (IDOC), the Idaho Department of Health and Welfare (IDHW), and the Judiciary. IDJC was assigned the administration of the funds appropriated to serve justice-involved juveniles and established the JJ SUD services delivery system.

In early 2012, administrators at IDJC contracted with researchers at the Center for Health Policy (CHP) at Boise State University to conduct a program evaluation of the Idaho JJ SUD services delivery system, which coordinates and funds treatment for justice-involved juveniles with substance use disorders. The first element of the evaluation involved establishing "baseline" information from the year (Fiscal Year [FY] 2011) prior to the one in which the JJ SUD services delivery system was initiated. To establish a set of baseline information, IDJC SUD program manager provided CHP researchers with billing data for 1,491 juveniles for whom charges were billed through the JJ SUD services delivery system in FY 2011. Included in the data set was information related to treatment episode start and end dates, patient gender and region, billing and treatment codes, provider names, and claim costs.

After substantial data "cleaning" and recoding of pertinent information into new variables, the researchers were able to develop responses to relevant questions about: 1) the number of clients receiving treatment through the JJ SUD services delivery system; 2) the amount of time juveniles spent in treatment and how often they were treated; 3) the amount of time elapsed between the determination of treatment need and the first receipt of treatment services; 4) the costs associated with providing and coordinating treatment; 5) the recidivism status of juveniles who received treatment services; 6) the costs of treating those juveniles who did and did not recidivate; and 7) the treatment factors associated with recidivism status. Major findings of the study included that, in FY 2011: a) the vast majority of juveniles received outpatient care as their primary mode of treatment; b) residential treatment involved more treatment sessions than outpatient treatment; c) juveniles, after being formally assessed, accessed treatment relatively quickly; d) the average (median) cost of treated juveniles was approximately $900, however there was wide variation in treatment costs; and e) approximately 38% of treated juveniles committed a non-traffic misdemeanor or felony within 12 months after treatment for which they were adjudicated. The second element of the evaluation involved the analysis of data collected on juveniles treated through the JJ SUD services delivery system in 2012, the first year that the system was administered through IDJC. In many respects, the data were similar to those analyzed by the CHP research team in the first element of the evaluation described above. Though the first year analyzed all billing data for those receiving services, the second year focused on clients discharged from their treatment episode. The research team was asked to answer the same basic questions as in the first evaluation element, and was also tasked with analyzing the data from an internet survey of stakeholders (such as county juvenile justice staff, chief juvenile probation officers/directors, and treatment providers) on the new JJ SUD services delivery system. The results from analyses of each of these waves of data are provided in this report.

Methodology

Data presented in this report were collected in two separate waves. The first wave involved the IDJC SUD program manager extracting data pertinent to this evaluation project from databases maintained by the IDJC and providing the data to the CHP researchers. The second wave involved using an internet-based survey to solicit feedback from stakeholders working with justice-involved juveniles in Idaho on how well the Idaho JJ SUD services delivery system is functioning.

Wave One: IDJC Data

In late August 2012, two databases were provided by the IDJC SUD program manager to the CHP researchers, including a Microsoft Excel database and a Statistical Package for the Social Sciences (SPSS) database. The Microsoft Excel database consisted of the identification numbers of juveniles who had been treated through the JJ SUD services delivery system in FY 2012, their gender, county of supervision, discharge reason, total cost of treatment, and length of stay. The SPSS database contained additional information on the treatment histories of the juveniles, including all claims data. In early October 2012, an additional database was provided by IDJC project manager to the CHP researchers. This database contained filing dates of criminal charges for the juveniles who had been treated through the JJ SUD services delivery system and released in the first quarter of FY 2012. Ultimately, information from the three databases was combined into one SPSS database so that the CHP researchers could assess for any potential associations between treatment-related factors (e.g., length and cost of treatment) and whether or not juveniles recidivated, defined as having been adjudicated of a misdemeanor or felony after the termination of treatment.

The two databases that were provided by the SUD program manager to the CHP researchers in late August 2012 were combined into one SPSS database and inspected for consistency to ensure that the CHP researchers had the necessary information to address the research questions. Once the two databases were combined, it became apparent that some data cleaning efforts would be required. For instance, it was noted that a number of juveniles were listed twice in the Excel database. In an ongoing conversation with the SUD program manager, it was concluded that the 35 cases that appeared twice in the Excel database were juveniles who had two documented treatment episodes and determined that their two treatment episodes would be combined into one. As a result, the number of cases in the database decreased from the initial 582 to 547. Furthermore, some juveniles had a documented treatment episode start date prior to FY 2011, and there were some expenditure activities that seemed to have occurred outside of the episode start and end dates (in these cases, it was impossible to determine whether the expenditure detail was related to the discharge code or whether it represented an unrelated prior or subsequent treatment episode). In order to address these problems associated with the final database, it became necessary to develop several exclusion criteria to remove cases that were not “clean” enough to be included in the final analyses (in other words, cases that contained inconsistencies that could compromise the quality of the results). The exclusion criteria were developed jointly by the SUD program manager and the research team. After the data were cleaned through the exclusion of inconsistent cases, they were recoded or transformed as necessary and entered into the SPSS database for analysis. In this section of the report, the exclusion criteria and transformation into variables for analysis are sequentially discussed.

Exclusion Criteria

As the system data was comprehensive and included treatment activity prior to the start of the JJ SUD System, it was necessary to analyze and exclude some cases. Three exclusion criteria were collaboratively developed, and included the following: 1) whether an assessment or treatment service was provided in FY 2012; 2) whether an expenditure activity occurred outside of the episode start and end dates; and 3) whether a treatment episode started prior to FY 2011. As the result of these data-cleaning efforts, a total of 226 of the 547 cases of juveniles receiving services through the JJ SUDS services delivery system that were included in the database provided by IDJC to the research team were excluded from the final analysis. Thus, the present report is based on the data collected on 321 juveniles who met all inclusion criteria (or alternately, did not meet any of the exclusion criteria).

The first exclusion criterion pertained to the services provided to juveniles through the JJ SUDS services delivery system. Many cases were included in the original database that were not part of the JJ SUDS delivery system. Individuals who received neither an assessment nor a treatment service in FY 2012 were excluded from the analyses discussed in this report. Eighty-eight cases were removed based on this criterion.

The second exclusion criterion was related to the expenditure activities; individuals with an expenditure activity occurring outside of the episode start and end dates were systematically excluded from the analysis. This resulted in the exclusion of 125 cases.

The JJ SUD services delivery system database that was delivered to the research team by IDJC was mostly comprised of the service delivery data for FY 2012 (some juveniles had a treatment episode start date in FY 2011 and were included in the final dataset); however, some data contained in this database were from the years prior to FY 2011. To ensure accuracy in reporting, all treatment episodes that had a start date prior to FY 2011 (designated in the data set as "start of episode") were excluded from the final analyses. Thirteen cases were excluded based on this criterion.

Variables for Final Analysis

When IDJC and CHP completed the scope of work for the contractual agreement, eight research questions about the FY 2012 data were identified. The finalized SPSS database contained the following variables to respond to the requested questions.

Patient ID. Identification (ID) numbers were used to identify each juvenile in the database and allowed the juveniles to be anonymous while still permitting the researchers to match information (e.g., treatment events, recidivism status) at the individual level.

Gender. The gender of each juvenile was included in the database to allow for relevant comparisons.

District. The IDJC district for each juvenile was included in the database to allow for relevant comparisons.

Cost per Patient. The total cost per patient (sum of all billing costs) for each juvenile was entered into the SPSS database.

Length of Stay. The total treatment time (calculated by subtracting the "episode start date" from the "episode end date") for each juvenile was noted in days in the SPSS database.

Number of Episodes. Number of episodes for each juvenile was noted in the SPSS dataset. A treatment episode is defined as the time from "episode start date" to "episode end date." Because only three juveniles who had two treatment episodes remained in the final database (i.e., after those cases that met one or more of the exclusion criteria were removed), this variable was not used in any of the analyses discussed in this report.

Type of Service. Type of service provided was documented for each juvenile in the IDJC database. Two types of service provided were:

- Assessment only – juvenile received an assessment that was not followed by a treatment
- Assessment and Treatment – juvenile received both an assessment and treatment

Time between Assessment and Start of Treatment. The total treatment time was calculated by subtracting the date of initial screening assessment (denoted in the IDJC database by the first Healthcare Common Procedure Code [HCPC] H0001 – Alcohol and/or drug assessment for each juvenile) from the date of first treatment, denoted in the IDJC database by one of the following treatment codes:

- H0004 – Behavioral health counseling and therapy, per 15 minutes;
- H0005 – Alcohol and/or drug services; group counseling by a clinician;
- H0008 – Alcohol and/or drug services; sub-acute detoxification [hospital inpatient];
- H0017 – Behavioral health; residential [hospital residential treatment program] without room and board, per diem;
- H0018 – Behavioral; short-term residential [short-term residential treatment program] without room and board, per diem;
- 90847 – Family psychotherapy [conjoint psychotherapy with patient present].

The calculated scores were then entered into the SPSS database.

Treatment Frequency. All treatment sessions (denoted by a treatment code of H0004, H0005, H0008, H0017, H0018, or 90847) for each juvenile who received any treatment in FY 2012 were summed, and the total number of treatment events per patient was entered into the SPSS database.

Mode of Treatment. Mode of treatment was documented for each juvenile who received any treatment in FY 2012. Two modes of treatment were documented: Outpatient (treatment instances categorized as Level I – Outpatient and Level II – Intensive Outpatient were combined to form one larger category, Outpatient) and Residential (treatment categorized as Level III.5 – Residential). Juveniles receiving outpatient treatment only were categorized as Outpatient; juveniles receiving any residential treatment (either alone or in combination with Outpatient) were categorized as Residential.

Primary Provider. A primary provider was noted for each juvenile who received any treatment in FY 2012. In cases in which juveniles were treated by two providers with equal frequency, no primary provider was noted.

Discharge Reason. The reason for discharge is reported by the provider for each discharged case. One of the following discharge reasons was documented for each juvenile in the IDJC database:

- Completed Treatment Successfully;
- Dropped Out against Professional Advice;
- Terminated by Facility;
- Incarceration Court Intervention;
- Client Moved, Unknown

The discharge reason associated with the most recent treatment episode was used for the three juveniles who had two documented treatment episodes.

YLS/CMI Scores. The following Youth Level of Service/Case Management Inventory (YLS/CMI) scores were documented for some juveniles in the IDJC database:

- YLS/CMI Domain 1 – Prior and Current Offenses/Dispositions
- YLS/CMI Domain 2 – Family Circumstances/Parenting
- YLS/CMI Domain 3 – Education/Employment
- YLS/CMI Domain 4 – Peer Relations
- YLS/CMI Domain 5 – Substance Abuse
- YLS/CMI Domain 6 – Leisure/Recreation
- YLS/CMI Domain 7 – Personality/Behavior
- YLS/CMI Domain 8 – Attitudes/Orientation
- YLS/CMI Total Score

Year of Assessment. The year of initial assessment for each juvenile who received an assessment in either FY 2012 or FY 2011 was entered in the SPSS database (as previously noted, some juveniles had a treatment episode start date in FY 2011 and were included in the final dataset—provided they had at least some treatment in FY 2012).

Recidivism Status. The final database that was provided by IDJC to the research team in October 2012 contained filing dates of criminal charges for juveniles who were discharged in the first quarter of FY 2012. In the SPSS database, researchers noted whether or not each juvenile had committed a felony or misdemeanor that was not traffic-related within 12 months and subsequently adjudicated on that charge (i.e., had recidivated) after the completion of the last treatment session (again denoted by a treatment code of H0004, H0005, H0008, H0017, H0018, or 90847).

Wave Two: Stakeholder Survey

The second wave of data presented in this report was gathered through an internet-based survey of professionals working with the justice-involved juveniles in Idaho. The survey consisted of 22 items asking about respondents' professional backgrounds and their views about a number of topics related to the JJ SUD services delivery system. The primary aim of the survey was to solicit feedback from stakeholders that could be used in future development of the JJ SUD services delivery system. The survey items were collaboratively developed by the JJ SUD program manager and CHP researchers. A draft of the survey was made available electronically to a group of professionals working with the justice-involved juveniles in different capacities (e.g., providers, county juvenile justice staff, court administrators, and probation officers). These

individuals were asked to provide feedback on the clarity of the questions, appropriateness of the response options, and to offer comments and suggestions regarding whether items should be added, removed, and so forth. As a result, some minor changes were made to the survey items and a 22-item survey was finalized in September 2012. This survey consisted of 17 closed-ended (i.e., multiple-choice) and five open-ended (i.e., "write-in") items.

After the survey items were finalized, the CHP research team created an internet-based survey using the Qualtrics Online Survey Software package for which BSU has a site license. The Qualtrics software allows programmers to create not only "boxes" for respondents to check for closed-ended items, but also to place text boxes so that respondents can type responses to open-ended questions. It also allows for "skip patterns" to be created, so that if a respondent provides an answer that makes the next item inappropriate for him or her to receive, the next item will be "skipped" (for example, if an initial item asks whether a respondent is a provider, and the next item is for judges only, that respondent can be skipped past that item and on to the next item appropriate for him or her). The survey was programmed into Qualtrics by mid-September 2012, and the survey link was sent to the JJ SUD program manager.

Recruitment of the participants was conducted directly by the JJ SUD program manager, who sent an initial invitation and link to the Qualtrics survey (which was hosted on the BSU server) on September 14, 2012. Respondents began to complete the survey the same day. The JJ SUD program manager send two 'reminder' email messages encouraging potential respondents to complete the survey. The first reminder message was sent on September 21, 2012, and the second reminder message was delivered six days later, on September 27, 2012. The survey was closed on October 5, 2012, and at this time, a total of 128 respondents had completed it.

Results

Analysis of the IDJC Data

Demographics

Gender. Males accounted for 75.7% (N = 243) of the 321 juveniles included in the population for final analysis, and 24.3% (N = 78) were females.

Patient District. As seen below in Table 1, the largest numbers and percentages of juveniles included for final analysis were from District 4 and District 3 (both just over 21%), followed by District 7 (nearly 19%). The smallest numbers and percentages of juveniles were from District 2 and District 6 (both approximately 9%)(see Table 1).

Table 1: Number and Percentage of Cases by Patient Region

JDC Location	Number of Cases	Percentage of Total Cases
District 1 – Panhandle	35	10.9
District 2 – North Central	28	8.7
District 3 – Southwest	68	21.2
District 4 – Central	68	21.2
District 5 – South Central	33	10.3
District 6 – Southeastern	29	9.0
District 7 – Eastern	60	18.7

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

Assessment and Treatment Services. Two hundred eighty-one or 88% of juveniles received an assessment followed by treatment and 40 juveniles or nearly 12% received an assessment but no treatment services.

Modes of Treatment/Levels of Care. A total of 243 juveniles, or 86.5% of those for whom a level of care was noted, received only outpatient care. The remaining 38 juveniles, or 13.5% of those for whom a level of care was noted, received at least some residential care.

Primary Provider of Care. Primary providers of outpatient care were noted for 283 juveniles. As seen below in Table 2, the most common providers of outpatient care were D7 Treatment Services (nearly 12% of juveniles for whom an outpatient provider was noted) and Family Services Center (over 11%). The next-most common providers included Ada County Juvenile Court Services (26; slightly over 9%), Ascent Behavioral Health Services (24; nearly 9%), and Alliance Family Services and Bannock Youth Foundation (both 20, or slightly over 7%).

Table 2: Most Common Providers of Outpatient Treatment		
JDC Location	**Number of Cases**	**Percentage of Total Cases**
D7 Treatment Program	33	11.7
Family Services Center	32	11.3
Ada County Juvenile Court Services	26	9.2
Ascent Behavioral Health Services	24	8.5
Alliance Family Services	20	7.1
Bannock Youth Foundation	20	7.1
Preferred Child and Family Services	19	6.7
Nez Perce County Court Services	18	6.4
Walker Center – SSA	15	5.3
Recovery 4 Life	13	4.6
A to Z Family Services	10	3.5

Note. Percentages are calculated out of juveniles for whom a primary outpatient or intensive outpatient provider was noted. It is possible that a primary provider for both outpatient and intensive outpatient treatment for a given juvenile are both noted.

Primary providers of residential care were noted for 28 juveniles. The two most common providers of residential care were Bannock Youth Foundation (10 juveniles, or 35.7% of those for whom a residential provider was noted) and Bell Chemical Dependency (eight juveniles, or 28.6% for whom a residential provider was noted).

Discharge Reason. A discharge reason was documented by providers for all 321 juveniles. As seen below in Table 3, the two most common discharge reasons were "Completed Treatment Successfully " and "Client Moved, Unknown" (125 juveniles each, or nearly 39% of all juveniles). The least common discharge reasons were Incarceration Court Intervention (20; just over 6%) and "Terminated by Facility" (14; slightly over 4%).

Table 3: Most Common Discharge Reasons		
JDC Location	**Number of Cases**	**Percentage of Total Cases**
Completed Treatment Successfully	125	38.9
Client Moved, Unknown	125	38.9
Dropped Out or against Professional Advice	37	11.5
Incarceration Court Intervention	20	6.2
Terminated by Facility	14	4.4

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

***YLS*/CMI Scores.** Youth Level of Service/Case Management Inventory (YLS/CMI) scores were noted for 117 juveniles (or nearly 42% of juveniles who received any treatment). The average YLS/CMI Total score (sum of the eight YLS/CMI Domain scores) was 16.65 (standard deviation = 6.88), with a range from 2-37. The individual YLS/CMI domain scores were provided for 96 juveniles (or slightly over 34% of juveniles who received any treatment).

Year of Assessment. More than half of the juveniles (192, or 59.8% of all juveniles) were assessed in FY 2011 and transferred to the new JJ SUD system on July 1, 2012, and the remaining 129 (or 40.2% of all juveniles) received an assessment and began their treatment episode in FY 2012.

Research Questions. As discussed earlier in this report, the contractual agreement between IDJC and the CHP research team specified eight questions regarding the FY 2012 JJ SUD services delivery system data that should be addressed. They are addressed sequentially below.

Question 1: How many clients were provided treatment and discharged in the prior year (FY 2012)?

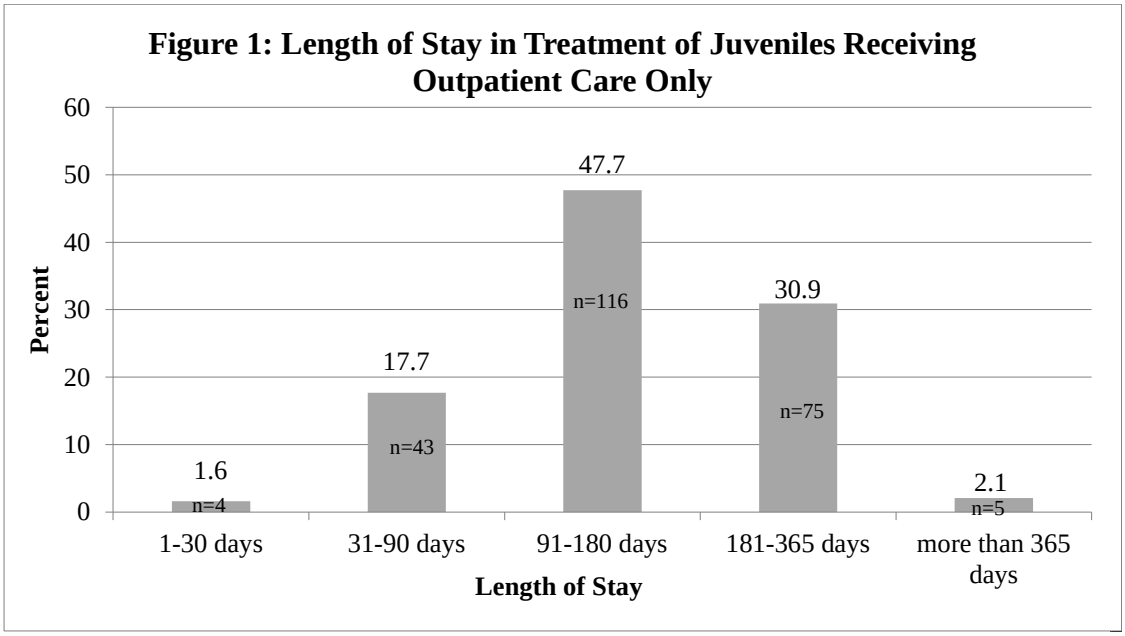
Data on 321 individuals who received either an assessment or treatment service (or both) and were discharged in 2012 are analyzed throughout this report. Of those 321 individuals, 281 were provided treatment during the evaluation period, with 40 individuals receiving assessment but no treatment services.

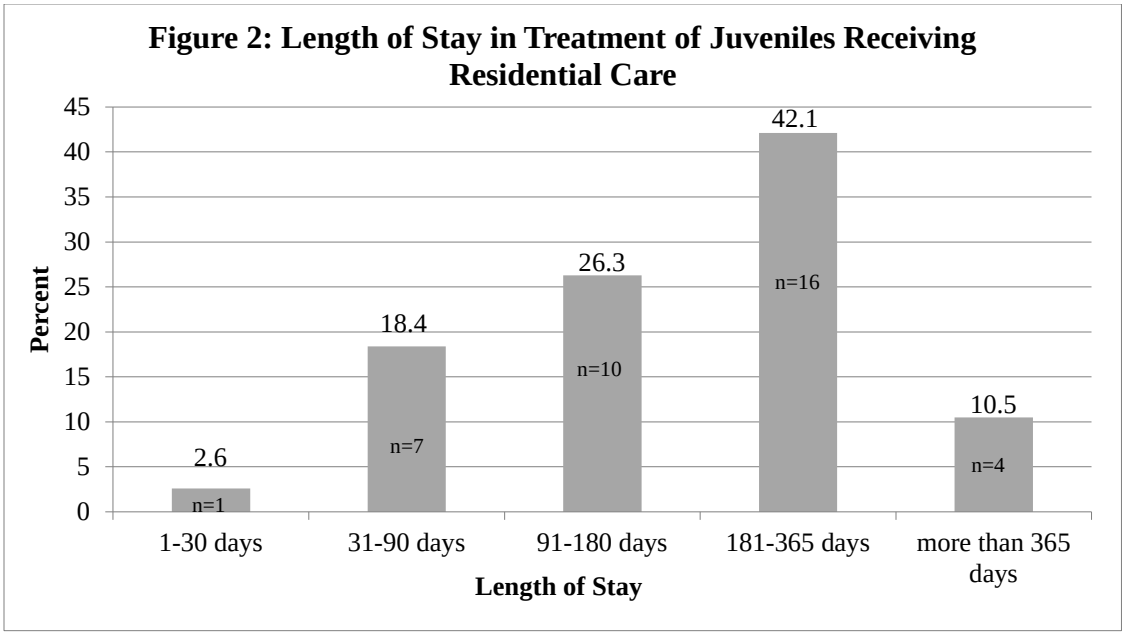
Question 2: What are the averages and ranges of length of stay and treatment frequency of all clients by level of care?

For the purposes of this study, "length of stay" is operationalized as the time from initialization of record in the JJ SUD services delivery system database to the final record in this database (in the database, these are noted as episode start date and episode end date, respectively). Also for the purposes of this study, "level of care" is operationalized as one of two levels of care: Outpatient (only Level I – Outpatient and/or Level II – Intensive Outpatient) and Residential (Level III.5 – Residential; juveniles who had at least some residential treatment, with or without any outpatient care, were coded with this level of care). As seen below in Table 4, the mean length of stay for all treated juveniles, regardless of level of care, was 169 days (or approximately 5.5 months), with a range between 14 days and 533 days (nine individuals had a reported length of stay of more than 365 days) (depictions of the ranges of treatment stays as a function of level of care are also presented below in Figures 1 and 2). With respect to length of stay as a function of level of care, a statistically significant difference was found between the two primary levels of care. This finding was accounted for by juveniles who received residential care (i.e., residential care either alone or in addition to outpatient care) having a significantly longer mean length of stay (approximately 213 days) than juveniles who had outpatient treatment only (approximately 162 days), $t\ (279) = -3.24$, $p < .01$ (see Table 4).

Table 4: Average Length of Stay by Primary Level of Care		
Level of Care	**Length of Stay in Days (Total Treatment Episode)**	
	Mean (Standard Deviation)	**Range**
Outpatient Only	161.77 (83.94)	22 – 513
Residential	212.74 (123.49)	14 – 533
Total	168.67 (91.70)	14 – 533

Note. The values in this table are calculated out of the 281 juveniles who were provided any treatment in FY 2012. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values.



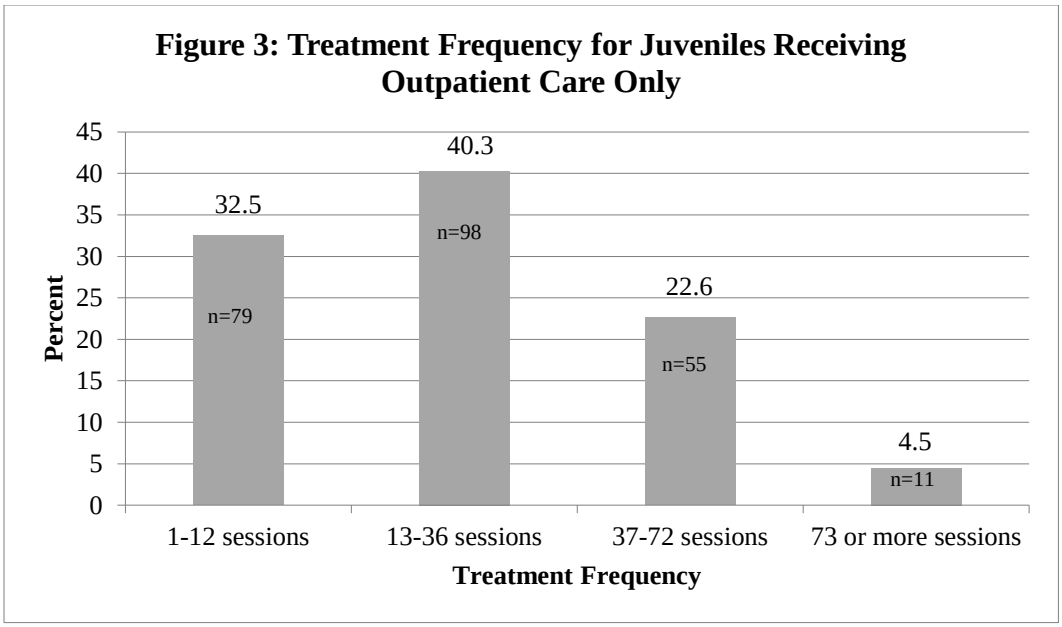


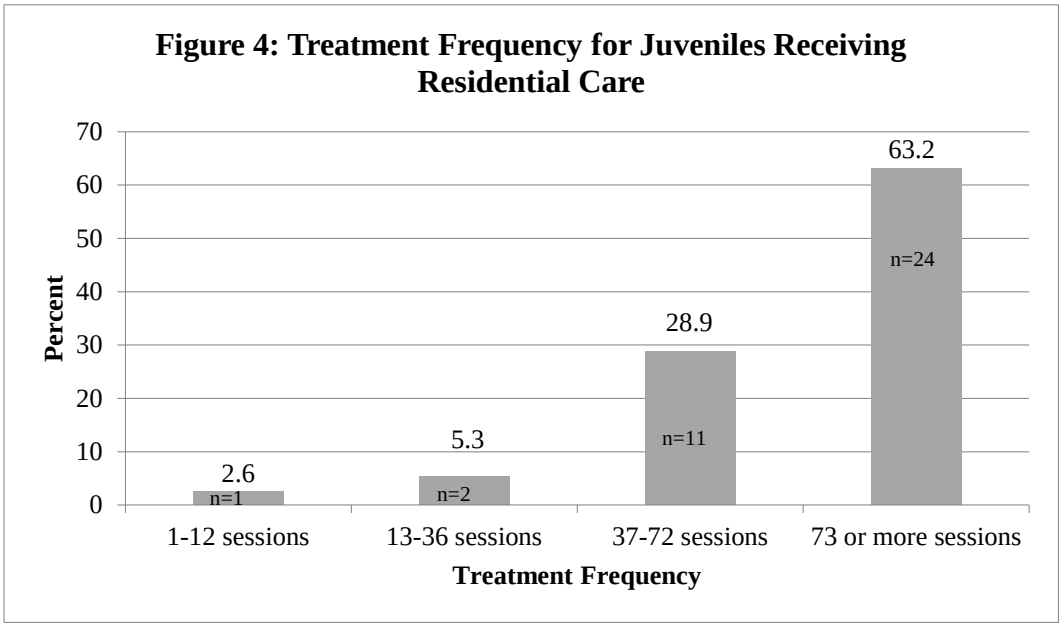
For the purposes of this study, "treatment frequency" is operationalized as the number of sessions a provider billed for a client. As seen below in Table 5, the average (mean) treatment frequency for all treated juveniles, regardless of level of care, was approximately 35 sessions, with a range between one session and 183 sessions (depictions of the ranges of treatment frequencies as a function of level of care are also presented below in Figures 3 and 4). With respect to treatment frequency as a function of level of care, a statistically significant difference was found between the two primary levels of care. This finding was accounted for by juveniles who received residential care (again, meaning either residential care only or residential in addition to outpatient care) having a significantly greater mean treatment frequency (nearly 86 sessions) than those who received outpatient care only (nearly 27 sessions), t (279) = -13.41, p < .001 (see Table 5).

Table 5: Average Treatment Frequency by Level of Care

Level of Care	Treatment Frequency in Sessions	
	Mean (Standard Deviation)	Range
Outpatient Only	26.71 (22.72)	1 – 109
Residential	85.50 (37.22)	1 – 183
Total	34.66 (32.17)	1 – 183

Note. The values in this table are calculated out of the 281 juveniles for whom a primary mode of treatment/level of care was documented. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values.





Question 3: What is the average time between assessment and first treatment service?

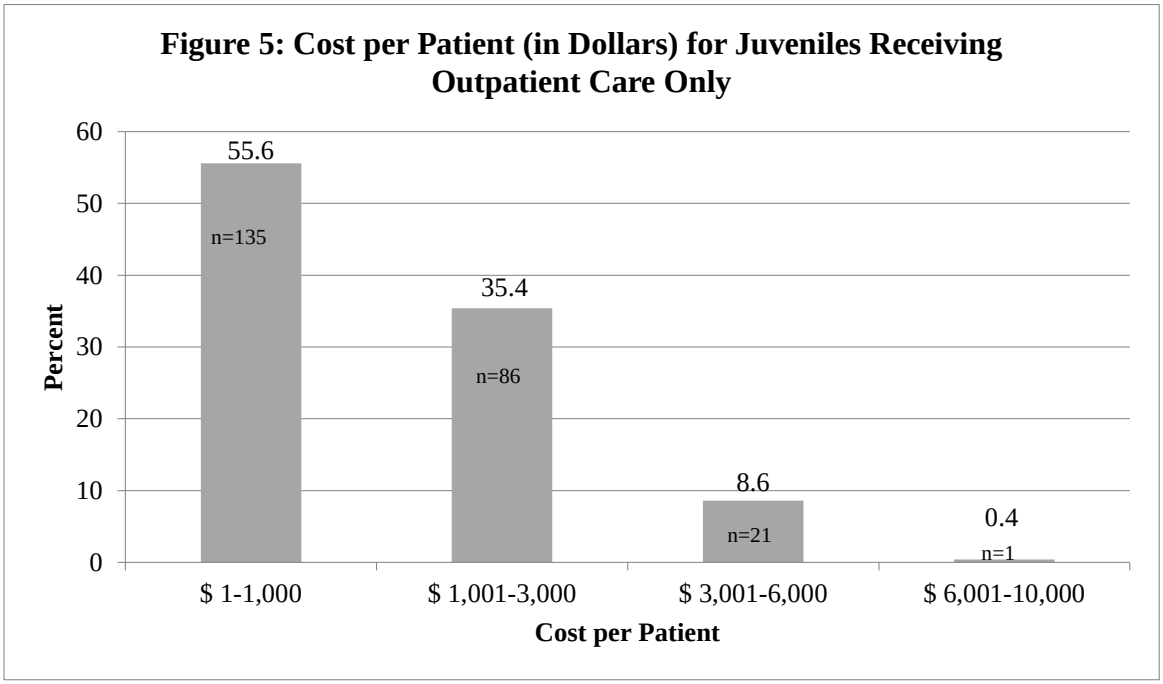
For the purposes of this study, "time between assessment and first treatment service" is operationalized as the length of time, in days, between the notation of the assessment billing code and a treatment billing code in the JJ SUD services delivery system database for each juvenile (this analysis was only performed on the 177 juveniles on whom assessment data were available). The mean length of time between assessment and first treatment service for all juveniles was 19.83 days (standard deviation = 18.49 days). The times between assessment and first treatment service ranged from the same day to 90 days (or approximately three months). Almost equal numbers of juveniles who received any treatment in FY 2012 received an assessment in FY 2012 (89 juveniles) and FY 2011 (88 juveniles). With respect to the average

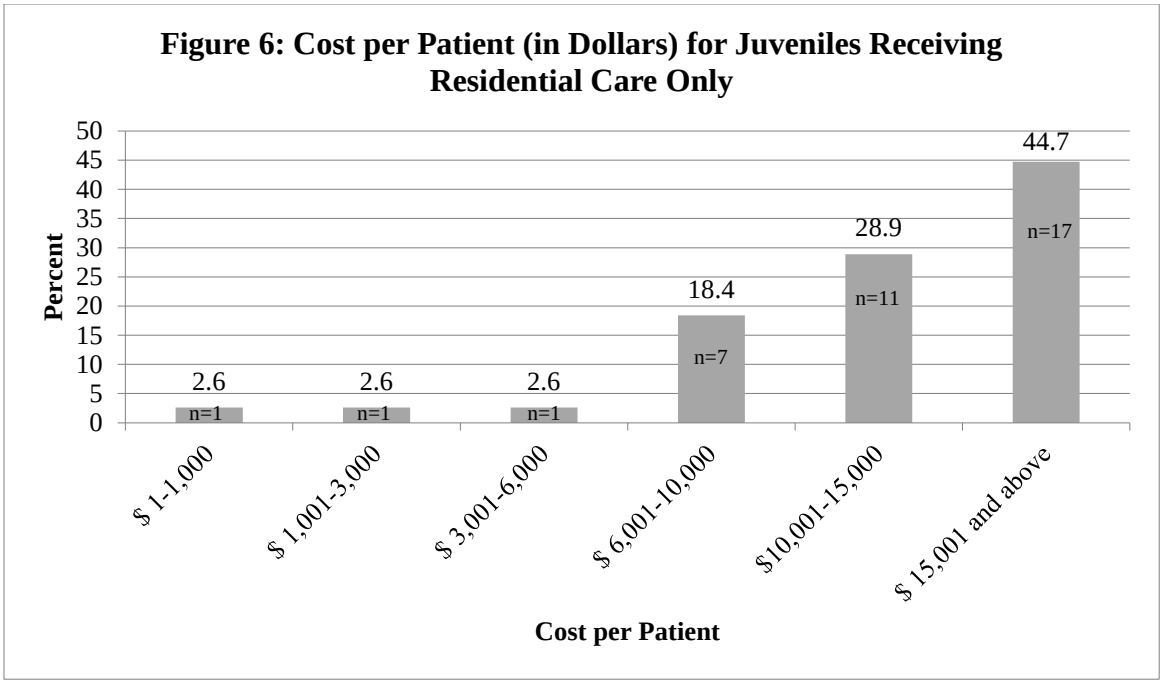
time between assessment and first treatment service as a function of year of assessment, a statistically significant difference was found, t (175) = 1.99, $p < .05$. This difference was accounted for by the juveniles assessed in FY 2012 (mean = 22.56 days, standard deviation = 21.09) having significantly longer average time between assessment and first treatment service than the juveniles assessed in FY 2011 (mean = 17.07 days, standard deviation = 15.05). Additional analysis will need to be conducted to understand these initial trends.

Question 4: What is the average and range of cost of all clients by level of care?

For the purposes of this study, "client cost" was operationalized as the sum of all charges billed for a juvenile in the JJ SUD services delivery system database, from the first to the final record. The mean client cost for all juveniles was $2,438.04 (standard deviation = $4,283.74). Client costs ranged from $10.64 to $20,422.50 (depictions of the ranges of client costs as a function of level of care are also presented below in Figures 5 and 6).

Figure 5: Cost per Patient (in Dollars) for Juveniles Receiving Outpatient Care Only





To analyze the average and range of client cost by level of care, only juveniles with a primary level of care were included. This was a total of 281 individuals (thus, 40 individuals who did not have a primary level of care indicated were not included in this part of the analysis). As seen below in Table 6, the mean client cost for all juveniles with an indicated primary level of care was more than $2,400, with a range between approximately $11 and over $20,000.

Table 6: Average Client Cost by Primary Level of Care

Level of Care	Client Cost in Dollars	
	Mean (Standard Deviation)	Range
Outpatient Only	1,191.41 (1,175.98)	10.64 – 7,377.46
Residential	12,859.63 (4,695.90)	165.38 – 20,422.50
Total	2,438.04 (4,283.74)	10.64 – 20,422.50

Note. The values in this table are calculated out of the 281 juveniles for whom a primary mode of treatment/level of care was documented. Standard deviations reflect the spread of values, with larger standard deviations indicating a wider spread of values.

Question 5: How many clients were provided treatment that did not relapse or recidivate by level of care?

For the purposes of this study, "recidivism status" is operationalized as whether or not a juvenile had been adjudicated of a misdemeanor or felony excluding traffic violations after the completion of treatment (denoted as the date of last treatment session documented in the JJ SUD services delivery system database). Recidivism data were provided for the 112 juveniles (or

slightly over 34.9% of juveniles included in the final SPSS database) who were discharged in the first quarter of FY 2012. As seen below in Table 7, 40% of treated juveniles who were discharged in the first quarter of FY 2012 were identified as having been adjudicated of a criminal charge (i.e., recidivated) after completion of the most recent treatment session (20 juveniles for whom recidivism data was provided were assessed but not treated).

Table 7: Recidivism Rates of Treated Juveniles by Primary Level of Care

Level of Care	Recidivism Status (Percentage) (Number)	
	No New Criminal Offense	New Criminal Offense
Outpatient Only	60.5 (46)	39.5 (30)
Residential	56.2 (9)	43.8 (7)
Total	59.8 (55)	40.2 (37)

Note. The values in this table are calculated out of the 92 juveniles for whom a primary mode of treatment/level of care was documented. Percentages are rounded to the first decimal place, so the total row percentage may not equal 100.

Question 6: What is the average length of stay and cost for those who did not relapse or recidivate?

The average length of stay for those juveniles who did not recidivate was 162.26 days (standard deviation = 102.06), and the average length of stay for juveniles who did recidivate was 143.74 days (standard deviation = 102.36). This difference was not statistically significant, t (110) = .94, p = .35. The average cost for those juveniles who did not recidivate was $2,759.06 (standard deviation = $4,168.85) and the average cost for those who did recidivate was $2,605.64 (standard deviation = $4,235.67). This difference was also not statistically significant, t (110) = .19, p = .85. Thus, length of stay in treatment and cost of treatment do not seem significantly different between those who recidivated and those who did not in this initial data set.

Question 7: What factors are statistically significant in determining successful treatment episodes?

To investigate what factors, if any, were significantly related to whether or not a juvenile recidivated, several variables were subjected to initial univariate analyses to determine whether they were independently associated with recidivism status. The expectation was that, if more than one variable was independently associated with recidivism status, a multivariate analysis of these variables would be conducted to determine which variables were *most strongly* predictive of whether or not a juvenile recidivated. The variables subjected to univariate analysis included: a) juvenile gender; b) patient region; c) discharge reason; d) type of services provided (comparing juveniles who received an assessment only or both an assessment and treatment); e) cost per patient (as a categorical variable, using the cost categories shown in Figure 3); f) length of stay in treatment (as a categorical variable, using the length of stay categories shown in Figure 1); g) treatment frequency (as a categorical variable, using the frequency categories shown in

Figure 2); h) length of time between initial assessment and the start of treatment (as a categorical variable, comparing those receiving a first treatment within 10 days of assessment and those receiving a first treatment 11 or more days after assessment); and i) YLS/CMI individual domain and total scores.

Only one univerate analysis showed a significant association between a variable and recidivism status. This analysis revealed that length of time between initial assessment and the start of treatment, χ^2 (df = 1) = 6.68, $p < .05$ was significantly associated with whether or not a juvenile recidivated. This difference was accounted for by juveniles who received a first treatment 11 or more days after assessment (at slightly over 43%) recidivating significantly more often than juveniles who received a first treatment within 10 days of assessment (at nearly 14%). Due to the relatively small number of juveniles for whom recidivism data were available, it is perhaps unwise to conclude much about the importance of this finding, or about the lack of significant results involving the other variables. In short, analyses in future years involving a greater number of juveniles will likely yield more precise and accurate information regarding what (if any) factors predict whether or not a treated juvenile recidivates.

Analysis of the Stakeholder Survey Data

Demographics

Profession/Work Area. As seen below in Table 8, the largest numbers of respondents who completed the survey identified themselves as county juvenile justice staff (close to 34% of the total respondents), chief juvenile probation officers or directors (just under 25%), and providers (just over 19%). Representation was very low from juvenile court legal branch staff; as seen in Table 8, only two judges (less than 2% of the total respondents) and one court administrator (less than 1%) completed the survey. Of the 128 individuals who completed the survey, 20% entered their profession as "Other." The professions that the respondents in this category most frequently wrote in were juvenile probation officer (JPO)(four respondents) and IDJC (three respondents).

Table 8: Respondent Profession/Work Area

Profession/Work Area	Number of Cases	Percentage of Total Cases
County Juvenile Justice Staff	42	33.6
Chief Probation Officer/Director	31	24.8
Other	25	20.0
Provider	24	19.2
Judge	2	1.6
Court Administrator	1	0.8

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentages are calculated from the 125 respondents who completed this item (three respondents did not).

Length of Time Worked with Juveniles. The next item on the survey asked respondents to indicate the length of time they had worked with juveniles; six time categories ranging from two years or less to more than 20 years were presented as response options. As seen in Table 9

below, the largest single group of respondents (over 23%) reported having worked with juveniles for 6-10 years; the next-largest groups reported working with juveniles for 11-15 years (just under 22%), 16-20 years (close to 18%), more than 20 years (just over 16%), and 3-5 years (over 15%). The single smallest group of respondents reported working with juveniles for two years or less (less than 6%). Overall, nearly 80% of respondents reported having worked with juveniles for more than six years, and more than 55% reported working with juveniles for 11 or more years.

Table 9: Length of Time Worked with Juveniles

Length of Time in Years	Number of Cases	Percentage of Total Cases
2 Years or Less	7	5.6
3-5 Years	19	15.3
6-10 Years	29	23.4
11-15 Years	27	21.8
15-20 Years	22	17.7
More than 20 Years	20	16.1

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentages are calculated from the 124 respondents who completed this item (four respondents did not).

JJ SUD Services Delivery System

Juveniles' Ability to Receive Services. The first item on the survey asked respondents whether they agreed that juveniles on probation are able to receive services in the new JJ SUD delivery system. As seen below in Table 10, the vast majority (nearly 92%) of respondents strongly agreed (nearly 59%) or agreed (over 33%) that juveniles on probation in need of SUD treatment are able to receive services in the new JJ SUD delivery system. Only nine respondents (or slightly over 7%) strongly disagreed with the statement that juveniles on probation in need of SUD treatment are able to receive services in the new JJ SUD delivery system. One respondent, representing slightly less than 1% of those who completed this item, reported that he or she neither agreed nor disagreed with this statement.

Table 10: Juveniles' Ability to Receive Needed Services

Item: Juveniles on probation in need of SUD treatment are able to receive services in the new JJ SUD delivery system.

Response	Number of Cases	Percentage of Total Cases
Strongly Agree	74	58.7
Agree	42	33.3
Neither Agree nor Disagree	1	0.8
Disagree	0	0.0
Strongly Disagree	9	7.1

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentages are calculated from the 126 respondents who completed this item (two respondents did not).

Further analysis revealed that the length of time working with juveniles was significantly and inversely related to the perception of juveniles' ability to receive services in the new JJ SUD delivery system. Respondents who reported having been working longer with juveniles were less likely to agree with the statement that juveniles on probation in need of SUD treatment are able to receive services in the new JJ SUD delivery system, r (126) = -.27, p < .01.

Juveniles' Ability to Access the Appropriate Level of Care. The second item asked respondents whether they agreed that juveniles on probation in need of SUD treatment are able to access the appropriate level of care to meet their individual needs in the new JJ SUD delivery system. As seen below in Table 11, the vast majority (85%) of respondents strongly agreed (more than 47%) or agreed (nearly 38%) that juveniles on probation in need of SUD treatment are able to access the appropriate level of care to meet their individual needs in the new JJ SUD delivery system. Nearly 12% of respondents either strongly disagreed (slightly over 6%) or disagreed (nearly 6%) that juveniles on probation in need of SUD treatment are able to access the appropriate level of care to meet their individual needs in the new JJ SUD delivery system. Four respondents, representing just over 3% of those who completed this item, reported that they neither agreed nor disagreed with this statement.

Table 11: View on Juveniles' Ability to Access Appropriate Level of Care

Item: Juveniles on probation in need of SUD treatment are able to access the appropriate level of care to meet their individual needs in the new JJ SUD delivery system.

Response	Number of Cases	Percentage of Total Cases
Strongly Agree	60	47.2
Agree	48	37.8
Neither Agree nor Disagree	4	3.1
Disagree	7	5.5
Strongly Disagree	8	6.3

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentages are calculated from the 127 respondents who completed this item (one respondent did not).

Further analysis revealed that the length of time working with juveniles was significantly and inversely related to the perception of juveniles' ability to access the appropriate level of care to meet their individual treatment needs in the new JJ SUD delivery system. Respondents who reported having been working longer with juveniles were less likely to agree with the statement that juveniles on probation in need of SUD treatment are able to access the appropriate level of care to meet their individual treatment needs in the new JJ SUD delivery system, r (127) = -.29, p < .01.

Length of Stay in Treatment. The next item asked respondents whether they agreed that the local authorization process allows juveniles to remain in treatment for an appropriate amount of time. As seen below in Table 12, the majority (82%) of respondents strongly agreed (more than 41%) or agreed (nearly 41%) that the local authorization process allows juveniles to remain in treatment for an appropriate amount of time. Just over 11% of respondents either strongly

disagreed (nearly 5%) or disagreed (over 6%) that the local authorization process allows juveniles to remain in treatment for an appropriate amount of time. Seven percent neither agreed nor disagreed with this statement.

Table 12: View on Juveniles' Ability to Access Appropriate Level of Care		
Item: The local authorization process allows juveniles to remain in treatment for an appropriate amount of time.		
Response	**Number of Cases**	**Percentage of Total Cases**
Strongly Agree	53	41.4
Agree	52	40.6
Neither Agree nor Disagree	9	7.0
Disagree	8	6.3
Strongly Disagree	6	4.7

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

Coordination of Treatment. Next, the respondents were asked whether they agreed that coordination of treatment with the judge's order and probation terms results in more likelihood of success for the juveniles. As seen below in Table 13, the majority (nearly 83%) of respondents strongly agreed (more than 39%) or agreed (more than 43%) that coordination of treatment with the judge's order and probation terms results in more likelihood of success for the juveniles. Only slightly over 6% of respondents either strongly disagreed (nearly 4%) or disagreed (over 2%) that coordination of treatment with the judge's order and probation terms results in more likelihood of success for the juveniles. Fourteen respondents, representing 11% of those who completed this item, reported that they neither agreed nor disagreed with this statement.

Table 13: View on Effectiveness of Coordination of Treatment		
Item: Coordination of treatment with the judge's order and probation terms results in more likelihood of success for the juveniles.		
Response	**Number of Cases**	**Percentage of Total Cases**
Strongly Agree	50	39.4
Agree	55	43.3
Neither Agree nor Disagree	14	11.0
Disagree	3	2.4
Strongly Disagree	5	3.9

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentages are calculated from the 127 respondents who completed this item (one respondent did not).

Length of the Process. All respondents were asked whether they agreed that the local authorization process has improved the time from referral to assessment. As seen below in Table 14, the majority (just over 78%) of respondents strongly agreed (43%) or agreed (just over 35%) that the time from referral to assessment has decreased with the local authorization process. Only close to 9% of respondents strongly disagreed (nearly 4%) or disagreed (nearly 5%) that the time

from referral to assessment has decreased with the local authorization process. Seventeen individuals, representing slightly over 13% or all respondents, neither agreed nor disagreed with this statement.

Table 14: View on Whether Time from Referral to Assessment has Decreased		
Item: The local authorization process has improved the time from referral to assessment.		
Response	**Number of Cases**	**Percentage of Total Cases**
Strongly Agree	55	43.0
Agree	45	35.2
Neither Agree nor Disagree	17	13.3
Disagree	6	4.7
Strongly Disagree	5	3.9

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

When asked whether they agreed that the local authorization process has improved the time from assessment to treatment, the majority (just under 79%) of respondents strongly agreed (over 38%) or agreed (nearly 41%) that the time from assessment to treatment has decreased with the local authorization process. Only close to 9% of respondents strongly disagreed (just under 4%) or disagreed (nearly 5%) that the time from assessment to treatment has decreased with the local authorization process (see Table 15). Sixteen individuals, representing nearly 13% or all respondents, neither agreed nor disagreed with this statement.

Table 15: View on Whether Time from Assessment to Treatment has Decreased		
Item: The local authorization process has improved the time from assessment to treatment.		
Response	**Number of Cases**	**Percentage of Total Cases**
Strongly Agree	49	38.3
Agree	52	40.6
Neither Agree nor Disagree	16	12.5
Disagree	6	4.7
Strongly Disagree	5	3.9

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

With respect to the time from assessment to treatment, a statistically significant difference was found as a function of respondent profession/work area, F (3, 118) = 2.73, $p < .05$. This difference was accounted for by chief probation officers and directors (mean = 4.42, standard deviation = 1.03) expressing significantly more agreement with the statement that the time from assessment to treatment has decreased with the local authorization process than the providers (mean = 3.67, standard deviation = 1.13).

Communication between Providers and Probation. Next, respondents were asked whether they agreed that communication between the providers and probation is critical to the success of the client. As seen below in Table 16, the vast majority (nearly 94%) of respondents

strongly agreed (over 77%) or agreed (over 16%) with this statement. Only less than 6% of respondents strongly disagreed that the communication between the providers and probation is critical to the success of the client. One respondent neither agreed nor disagreed with this statement.

Table 16: View on Importance of Communication between Providers and Probation

Item: Communication between the providers and probation is critical to the success of the client.

Response	Number of Cases	Percentage of Total Cases
Strongly Agree	99	77.3
Agree	21	16.4
Neither Agree nor Disagree	1	0.8
Disagree	0	0.0
Strongly Disagree	7	5.5

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100.

Further analysis revealed that the length of time working with juveniles was significantly and inversely related to the perception of importance of communication between the providers and probation. Respondents who reported having been working longer with juveniles were less likely to agree with the statement that the communication between the providers and probation is critical to the success of the client, $r\ (128) = -.20$, $p < .05$.

The respondents were also asked to indicate whether they agreed that communication between the providers and probation has been enhanced with local management of treatment services. As seen below in Table 17, the majority of respondents (over 77%) strongly agreed (just under 33%) or agreed (nearly 45%) that the communication between the providers and probation has been enhanced with local management of treatment services. Only slightly over 5% of respondents strongly disagreed (just over 3%) or disagreed (over 2%) that the communication between the providers and probation has been enhanced with local management of treatment services. Twenty-two individuals, representing just over 17% or respondents who completed this item, neither agreed nor disagreed with this statement.

Table 17: View on Effects of Local Management on Communication between Providers and Probation		
Item: Communication between the providers and probation has been enhanced with local management of treatment services.		
Response	**Number of Cases**	**Percentage of Total Cases**
Strongly Agree	42	32.8
Agree	57	44.5
Neither Agree nor Disagree	22	17.2
Disagree	3	2.3
Strongly Disagree	4	3.1

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentages are calculated from the 127 respondents who completed this item (one respondent did not).

Adequacy of Available Information. All respondents were asked whether they agreed that there is adequate information regarding the clients currently in treatment to allow oversight and local management. As seen below in Table 18, the majority (74%) of respondents strongly agreed (22%) or agreed (52%) that there is adequate information regarding the clients currently in treatment to allow oversight and local management. Less than 12% of respondents strongly disagreed (less than 4%) or disagreed (less than 8%) that there is adequate information regarding the clients currently in treatment to allow oversight and local management. Eighteen individuals, representing slightly over 14% of respondents who completed this item, neither agreed nor disagreed with this statement.

Table 18: View on Adequacy of Information to Allow Oversight and Local Management		
Item: There is adequate information regarding the clients currently in treatment to allow oversight and local management.		
Response	**Number of Cases**	**Percentage of Total Cases**
Strongly Agree	28	22.0
Agree	66	52.0
Neither Agree nor Disagree	18	14.2
Disagree	10	7.9
Strongly Disagree	5	3.9

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentages are calculated from the 127 respondents who completed this item (one respondent did not).

With respect to the adequacy of information regarding the clients currently in treatment, a statistically significant difference was found as a function of respondent profession/work area, F (3, 118) = 3.89, $p < .05$. This difference was accounted for by chief probation officers and directors (mean = 4.23, standard deviation = 1.18) expressing significantly more agreement with the statement that there is adequate information regarding the clients currently in treatment to allow oversight and local management than the providers (mean = 3.33, standard deviation = 0.87).

The respondents were also asked whether they agreed that there is adequate information regarding treatment expenditures to allow management and accountability of the system and as seen below in Table 19, the majority of respondents (67%) strongly agreed (over 21%) or agreed (nearly 46%) that there was adequate information regarding treatment expenditures to allow management and accountability of the system. Over 9% of respondents strongly disagreed (just under 4%) or disagreed (under 6%) that there was adequate information regarding treatment expenditures to allow management and accountability of the system. Thirty individuals, representing close to 24% or respondents who completed this item, neither agreed nor disagreed with this statement.

Table 19: View on Adequacy of Information to Allow Management and Accountability

Item: There is adequate information regarding treatment expenditures to allow management and accountability of the system.

Response	Number of Cases	Percentage of Total Cases
Strongly Agree	27	21.3
Agree	58	45.7
Neither Agree nor Disagree	30	23.6
Disagree	7	5.5
Strongly Disagree	5	3.9

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentages are calculated from the 127 respondents who completed this item (one respondent did not).

With respect to the adequacy of information regarding treatment expenditures, a statistically significant difference was found as a function of respondent profession/work area, F (3, 118) = 3.25, $p < .05$. This difference was accounted for by chief probation officers and directors (mean = 4.16, standard deviation = 1.21) expressing significantly more agreement with the statement that there is adequate information regarding treatment expenditures to allow management and accountability of the system than the providers (mean = 3.38, standard deviation = 0.82).

The next item on the survey was an open-ended item, which asked the respondents what additional information would be useful to their teams in managing the system. A total of 56 respondents (or 43.8% of those who completed a survey) provided a response to this question. Their responses were subjected to a content analysis procedure to identify common themes. As seen below in Table 20, the most common theme identified in response to this item (identified in the responses of 11 respondents) was that the communication between different parts of the system (particularly, the providers and probation) should be encouraged. The next most common themes identified in the responses to this item were that the system currently in place is working well and that no additional information is needed (identified in the responses of 10 and eight respondents, respectively).

Table 20: Additional Information Useful in Managing the System		
Response Themes	**Number of Cases**	**Percentage of Total Cases**
Encourage communication, information exchange, and collaboration between different parts of the system (particularly, between the providers and probation)	11	19.6
System that is currently in place is working well	10	17.9
No additional information is needed	8	14.3
Speed up the authorization process; Make the authorization process more efficient and consistent	5	8.9
More information is needed (e.g., treatment cost, types of treatment that are available, lists of providers)	4	7.1
Demographic and treatment outcome data is needed; A statewide evaluation is needed	3	5.4

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentage of total cases is calculated from the 56 respondents who completed this item.

Barriers and Challenges to System Access. Next, respondents were asked whether they perceived that there were barriers or challenges in the system that prevented access to services for juveniles in their area. As seen below in Table 21, 28% of the respondents reported that they did perceive that there were barriers or challenges in the system that prevented access to services for juveniles in their area, while nearly 49% reported that they did not. Twenty-nine respondents, representing just over 23% of all who completed this item, selected the "Don't know/Not sure" response.

Table 21: Perceived Barriers or Challenges to System Access		
Perceived Barriers or Challenges	**Number of Cases**	**Percentage of Total Cases**
Yes	35	28.0
No	61	48.8
Don't know/Not sure	29	23.2

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentages are calculated from 125 respondents who completed this item (three respondents did not).

The next item on the survey was an open-ended item, which asked the 35 respondents who selected "Yes" on the previous item to indicate what barriers or challenges in the new system they believed prevented access to services for juveniles in their area. All 35 respondents who selected "Yes" on the previous item typed a response to this question. These responses were subjected to a content analysis procedure to identify common themes. As seen below in Table 22, the most common theme identified in response to this item (identified in the responses of 15 respondents; or nearly 43%) was lack of service or transportation providers in the area. Other, less common themes identified in response to this item included that treatment was not available to non-adjudicated juveniles and that the authorization process needs to be standardized (identified in the responses of four and three respondents, respectively).

Table 22: Additional Information Useful in Managing the System		
Response Themes	**Number of Cases**	**Percentage of Total Cases**
Lack of providers/services; Transportation	15	42.9
Treatment not available to non-adjudicated juveniles	4	11.4
Authorization process needs to be standardized (e.g., providing clients with the treatment start date)	3	8.6
Limited access to inpatient care (e.g., lack of funds, difficult to get clients into inpatient care)	2	5.7
Use of a single provider/referral source; Elimination of client's ability to make a choice	2	5.7

Note. Percentage of total cases is calculated from the 35 respondents who completed this item.

Profession-Specific Items. The next five survey items were profession-specific. In other words, each of the five items targeted only one group of professionals who work with juveniles in Idaho. For example, if a respondent selected "Provider" on the item that asked respondents about their profession/work area, then he or she was directed to the item that targeted only that group of professionals. The first three of these five items were directed at those respondents who selected the "Chief Probation Officers/Directors" option on the item that asked about their profession/work area. The first of these three items asked chief probation officers and directors whether their county had county-funded programs for SUD treatment. As seen below in Table 23, 14 respondents (or just over 45% of those who self-identified as chief probation officers or directors) reported that their county has county-funded programs for SUD services and programs for probationers, while 17 (or nearly 55%) reported that it does not.

Table 23: Availability of County-Funded Programs for SUD Treatment		
Availability of County-Funded Programs	**Number of Cases**	**Percentage of Total Cases**
Yes	14	45.2
No	17	54.8
Don't know/Not sure	0	0.0

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentages are calculated from 31 respondents who completed this item.

The next item asked chief probation officers and directors who selected "Yes" on the previous item to provide their best estimate of the county funds used for SUD services and programs for probationers. Of the 14 individuals who indicated that their county had county-funded programs for SUD treatment, 11 provided an estimate of those funds. The mean best estimate of the county funds used for SUD services and programs for probations was $38,545.45 (standard deviation = $88,090.99), with a median value of $3,500.00; because of significant skewness (skewness = 3.14; this skewness was caused primarily by several extremely high estimates) in the distribution of data on this item, the median value should be considered the more accurate indicator of average best estimate of the county funds used for SUD services and programs for probationers in Idaho counties. The best estimates of the county funds provided by 11 chief probation officers and directors ranged from $1,000.00 to $300,000.00.

The third and final profession-specific item that was directed at chief probation officers and directors asked all chief probation officers and directors to provide their best estimate of the administrative time (in number of hours per week) used for SUD services in their county. Of the 31 respondents who self-identified as chief probation officers or directors, 25 provided their best estimate of the administrative time used for SUD services in their county. The mean best estimate of the administrative time used for SUD services was slightly over five hours (standard deviation = 7.82), with a median value of three hours; because of significant skewness (skewness = 3.94; this skewness was caused primarily by several unusually high estimates) in the distribution of data on this item, the median value should be considered the more accurate indicator of average best estimate of the administrative time used for SUD services in Idaho counties. The best estimates of the administrative time ranged from zero to 40 hours.

The next profession-specific item was directed at judges. It asked those respondents who selected "Judge" on the item that asked respondents about their profession/work area whether they agreed that as a judge hearing juvenile cases, they were able to access assessment and treatment services for the juveniles with a substance abuse issue. Both of the two respondents who self-identified as judges strongly agreed (50%) or agreed (50%) that they are able to access assessment and treatment services for the juveniles with a substance abuse issue.

The final profession-specific item was directed at those respondents who selected "Provider" on the item that asked about respondents' profession/work area. They were asked whether they agreed that there has been good support to the provider network in the transition process to a locally managed treatment system for juvenile justice clients. As seen below in Table 24, the majority (nearly 71%) of respondents strongly agreed (nearly 13%) or agreed (over 58%) that there has been good support to the provider network in the transition process to a locally managed treatment system for juvenile justice clients. Only somewhat over 8% of respondents strongly disagreed (just over 4%) or disagreed (just over 4%) that there has been good support to the provider network in the transition process to a locally managed treatment system for juvenile justice clients. Five individuals, representing nearly 21% of the respondents who completed this item, neither agreed nor disagreed with this statement.

Table 24: View on Level of Support to Provider Network

Item: There has been good support to the provider network in the transition process to a locally managed system for juvenile justice clients.

Response	Number of Cases	Percentage of Total Cases
Strongly Agree	3	12.5
Agree	14	58.3
Neither Agree nor Disagree	5	20.8
Disagree	1	4.2
Strongly Disagree	1	4.2

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentages are calculated from the 24 respondents who completed this item.

Feedback. The final item on the survey was an open-ended item, which asked all respondents to provide any feedback that could be helpful to IDJC in either supporting district teams or working with stakeholders as the JJ SUD delivery system develops. Of the 128

respondents who completed the survey, 31 (or just over 24%) typed in a response to this question. These responses were subjected to a content analysis procedure to identify common themes. As seen below in Table 25, the two most common themes identified in response to this item were that the system currently in place is working well (identified in the responses of 10 respondents, or over 32%) and that improvements are noticeable with the new system (identified in the responses of six respondents, or over 19%). Another, less common, theme identified in response to this item was that services should be made available to pre-adjudicated juveniles (identified in the responses of two respondents). Some additional feedback provided by the remaining 13 respondents who typed in responses to this item included that eliminating BPA would minimize confusion and make more funds available, that the authorization process should be sped up, that data on the recidivism rates and how funds are used is needed, that an individualized approach to care is needed, that communication needs to be streamlined, that adolescent counselors should be included in the review process, that too much information sharing could compromise confidentiality, that providers should provide automatic monthly updates to probation, that control and approval of funds should be done at the county level, and that it is good that feedback on how the system is working is being solicited. Because each of these responses was provided by only one respondent, they did not constitute themes.

Table 25: Feedback

Feedback Themes	Number of Cases	Percentage of Total Cases
Current system is working well	10	32.3
Perceivable improvements with the SUD system	6	19.4
Make services available to pre-adjudicated juveniles	2	6.5

Note. Percentages are rounded to the first decimal place, so the total percentage may not equal 100. Percentage of total cases is calculated from the 31 respondents who completed this item.